Comments by AFSCME Council 31 on the
Medicaid 1115 Waiver Draft Application

Submitted January 22, 2014

General Process Concerns

Many of the goals articulated on page 6 of the draft waiver application are laudable. We support funding housing and home visitation, better integrating delivery systems, improving the healthcare workforce, etc. But there are many important specifics still missing from the draft which make it difficult to state our position on the waiver application. Our greatest concern is the lack of financial information: about potential CNOM and potentially Medicaid matchable expenditures as well as details of how increased state and federal dollars would be expended. Lacking those specifics, it is difficult to assess the risks and rewards of a waiver. Requiring the submission of these written comments before a fully developed waiver application has been circulated limits the input of stakeholders and the utility of the written comments.

We note that the Governor's office committed to posting a completed waiver application with financial details before submission to CMS – a commitment made at the forum January 9. Fulfilling that commitment is essential for a transparent process. In addition, there should be regular legislative hearings in each chamber during the waiver negotiations detailing how Medicaid programs will be impacted, to ensure the process remains transparent to, and allows input from, stakeholders.

There are some new details in this draft, and a lot more about why the system serving individuals with developmental disabilities should be included. But many key questions remain which make it difficult to take a specific position on the waiver, most specifically the federal dollars that can be tapped and the state spending that can draw it down.

Delivery system transformation

This section relies heavily on the implementation of managed care, which the waiver application acknowledges is already underway. The new proposal in the waiver is an Innovation & Transformation Resource Center for technical assistance to facilitate the implementation of managed care. The funding source for the Resource Center would be Medicaid administration dollars, and it will be located in the Governor's new Office of Health Innovation and Transformation. What impact would this have on the DHFS budget? Would this be additional funding or would it shift away dollars needed to administer the growing Medicaid program?

In the discussion of the various models for transforming the Cook County and U of I hospital systems, the current draft reads as a list of possibilities. We urge that those systems and their stakeholders be closely involved in crafting the details of this section of the waiver. The two plans discussed for the rest of the hospital systems – incentive payments for hitting identified quality markers and an access assurance pool to help hospitals losing DSH funds – are presented without any sense of the size of the possible investment. That detail is needed. On the proposed Facility Closure and Conversion Funds, what role will the Health Facilities and Services Review Board play in determining which hospitals or nursing homes would qualify? The mission of the HFSRB is in part to determine our state's health system needs, and we

understand that the Board is developing a health plan for the state to address exactly these access questions, so we are surprised the Board isn't referenced here.

Population Health

We have two resource questions in this section: What level of funding would Regional Public Health Hubs need to be effective, and how would they be funded? We also urge that the Regional Hubs be operated by a public health department. This is especially important as the waiver envisions the Hubs informing the use of add-on funds to encourage provider participation.

Workforce

Our union greatly appreciates the goal of establishing living wages for all healthcare workers. This is not only a just goal, it is necessary to the successful implementation of the fourth pathway: Home and Community Based Services expansion and infrastructure development. It will also reduce training costs, as the current high turnover rates in many direct-care positions are related to low pay. Improving wages will reduce turnover and thus the cost of training.

Home and Community-Based Infrastructure, Choice, and Coordination

We are concerned that the goal of integrating the assessment tool across Medicaid and all disability programs is too ambitious. At the public forum January 9th, a representative of HMA acknowledged that developing a Universal Assessment Tool would require time. The current plan is to focus – as indicated in the draft waiver – on homecare for the elderly and

individuals with disabilities first. Other programs would be phased in later. If there is uncertainty as to whether and when a truly universal tool can be developed, that should be spelled out in the document. Illinois should not commit to developing such a tool without being sure it is possible to do so in a way that will benefit service recipients. Many stakeholders at the January forum expressed concern that the services they or their loved ones require would not be well integrated into such a tool. The argument put forward raises legitimate concerns. As so much of the caseload under the waiver will be medical in nature, it will be difficult to develop at UAT that does not follow a medical model. Such a model will not work well with programs that are, for example, residential or habilitative.

We are also concerned that the UAT is intended to eliminate inequalities between service system, both in terms of available services and in rate variations between and among disabilities. The waiver does not make it clear whether the intent is to raise all boats, or whether this will take place in a system of scarcity which may require winners and losers. Assigning each individual their own unique services based on their need evaluation sounds good, but improving services for some should not be achieved by removing services from someone else. This would run counter to the concept of individual choice of services.

We support a plan to expand services to individuals with developmental disabilities, but would like much more information about the plan to levy a provider tax. This system is currently severely underfunded, and needs more resources not only for staff retention through wages and benefits – an idea in the waiver we strongly support. The overall infrastructure of service delivery – for example staffing levels and nursing care – has been neglected as our state

has failed to provide a rate increase for the past six years and provider agencies have squeezed all aspects of services in a struggle to stay above water.

Utilization management is used extensively in the mental health section. Why is that a focus for this population, and how will it impact choice of provider and medication?

In the proposal to count SMHRF expenses as otherwise matchable, does this take into account the fact that SMHRFs are not providing acute inpatient care? They cannot under state statute. If SMHRFs can be considered for this treatment, why does the waiver not propose the same for public IMDs, which serve many Medicaid eligible individuals and thus avoid Medicaid costs for acute inpatient care?